

**TESTIMONY OF
MARTHA B. KNISLEY
DIRECTOR
D.C. DEPARTMENT OF MENTAL
HEALTH**

**ON THE
FY 2004 BUDGET REQUEST**

**BEFORE THE
COMMITTEE ON HUMAN
SERVICES
CHAired BY
COUNCILMEMBER SANDRA
(SANDY) ALLEN**

**MONDAY, MARCH 24, 2003
COUNCIL CHAMBER
JOHN A. WILSON BUILDING
1350 PENNSYLVANIA AVENUE, N.W.
10 A.M. TO 1 P.M.**

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- Good morning, Chairperson Allen, members of the Committee on Human Services and members of the Council.
- My name is Martha B. Knisley and I am the director of the D.C. Department of Mental Health. With me today at the table are Winford Dearing, acting senior deputy director and deputy director for finance and administrative services; Bradley King, interim chief finance officer; Ivy McKinley, director of human resources; and Dr. Steven Steury, chief clinical officer.
- Thank you for this opportunity to discuss our FY 2004 budget request and how vital this request is to continuing our very important work. I also want to express my appreciation to you, Chairperson Allen, the members of the committee and the Council for your support, guidance and forbearance as we travel this bumpy road to a new public mental health system.
- While the 2001 Court-ordered Plan established how this system will function, what services will be provided and how, who is qualified to provide those services and even the budget; nevertheless, we are the people implementing the Plan and learning each step of the way.

LESSONS LEARNED

- Before describing the details of our FY 2004 budget request, I want to say the new Department of Mental Health is a work in progress; a work in progress that is facing and overcoming major challenges encountered since this team came together in the summer of 2001.

- First and foremost, we regained control of the Department's operations, ended the receivership, and now we are on our way to meeting the exit criteria to satisfy the 1974 Dixon suit. I keep uppermost in my mind that District residents of all ages for decades were denied the mental health care they needed.
- We are implementing the Court-ordered Plan for the new mental health system. The Court-ordered Plan clearly articulated that the system needed direction to embrace change and that massive overhauling needed to occur to:
 - redefine the provider role.
 - establish a separate authority to oversee the system.
 - remedy the inadequate infrastructure of the system.
 - build productive collaboration and nurture optimism.
- The Plan laid out in specific detail new duties and powers for the Department, new functions and positions that needed to be established, requirements for funding, including establishing a coherent contracting system,
- The Plan articulated a blueprint for new crisis response and access points and requirements, for Core Service Agencies to serve as clinical homes for consumers and for new policies and program approaches to serving persons with co-occurring substance abuse and mental health problems. Core Service Agencies are required to meet federal standards for service delivery.
- The Plan called for building a new St. Elizabeths Hospital.
- The Plan requires a dramatic increase in new and improved service delivery capacity that includes building a full range of community-based services for children, adopting Assertive Community Treatment, which is an assertive outreach approach to bringing services to adults with very severe illnesses, such as supported employment, illness management (Multi-Agency Planning Team/MAPT) and a full range of crisis supports and housing supports.

- All of these requirements are in the Dixon exit criteria. This expansion requires DMH to more than double the number of consumers served in the system.
- Finally, the Plan requires DMH to implement new requirements for consumer protections.
- These requirements then were supplemented with statutory requirements in the Mental Health Service Reform Act of 2001, in my contract with Mayor Williams and now in performance-based budgeting.
- These changes led us to restructure the entire Department to meet these requirements and to look closely at efficiencies we could implement to assure that we could properly fund these required changes.
- We realized then that we were funded at a level twice that of any other jurisdiction in the country for both outpatient and inpatient services and that change could not be financed only with new resources. We also understood that to continue operating as is we would mean failure in meeting our mandates.
- Our restructuring included rule changes; establishing new positions, policies, procedures and provider requirements. It also included examining each of our functions and each job within the organization. Overall these changes have resulted in our re-directing over \$ 20 million in our existing budget for FY 2003.
- In some cases, we sought external consultation, information systems, billing, ACT, housing, children's services, to name a few areas.
- We also looked at areas where, by definition, we would gain efficiencies if we were successful in meeting the requirements of the Plan, such as moving from a two-campus hospital where staff were located in 44 buildings, hence we completely evaluated plant

operations at St. Elizabeths Hospital.

- In short, we conducted a lengthy and multi-faceted examination for restructuring. We met with labor, community groups, providers and other District and federal agencies. Even with constant discussions, we realize these changes are sometimes overwhelming, confusing and still out of reach for this struggling system.
- However, after a year and a half we had successfully exited the receivership and while we are underway with the restructuring, we know that we have much more to do.
- Upon close examination of our workforce, we determined that we needed to conduct a reduction in force to meet our mandates and produce the efficiencies necessary to meet the Court-ordered Plan and exit criteria. This was exacerbated but not caused by the District's budget problems. However, it was carried out at a time when there were not other resources in the District to meet the additional resource needs associated with the exit criteria.
- We presented a plan for reduction in force consistent with our overall restructuring to the Mayor. This was forwarded to the District Council as part of the revised FY2003 budget submission to Congress.
- We originally projected that we would reduce the work force by up to 235 employees. Through careful planning, we abolished only 188 positions Department-wide, resulting in a reduction in 27.8 percent of the management workforce, a 10.9 percent reduction in the supervisory workforce and 9.6 percent reduction in the non-supervisory workforce. Sixty-seven (67) of these abolished positions were vacant at the time of the reduction in force, resulting in 121 encumbered positions being abolished. Of that number, 14 people have been reassigned to date and 37 employees retired leaving, 70 persons still adversely affected. There were no clinical staff from the John Howard Pavilion whose positions were abolished.

- The reduction in force was carried out in accordance with District rules. However, these actions, many years of promises not kept and poor working conditions have strained labor relations.
- In my singularly focused attention to righting the wrongs done to people, particularly children who had no voice, I have not taken the time to heed the lessons taught me by my mother, a former shop steward, Employees must be a part of the change. Believe me, I learned my lesson. As more changes are certain, it is incumbent upon me and senior staff to build stronger working relationships with labor.
- We have also secured the help of IBM Change Management to assure we have taken the steps necessary to support this enormous change process.
- We regained control of the Department's finances and are building a sound financial structure that had not existed before. For 10 years, the city bridged the DMH budget gap caused by inaccurate Medicaid and Medicare revenue projections. These faulty projections totaled \$62 million for FY 2001. In one year though we closed that gap going from red ink to black.
- At St. Elizabeths Hospital, we regained control of patient care, earning a clean federal evaluation of our operations for the first time in six years. We also consolidated our operations on one side of the 300 plus acre campus to allow us to better manage our resources.
- Additionally, we are moving forward with construction of the new hospital building. Earlier this month, the Zoning Commission conducted a hearing on the first stage of our request and the next step is the hearing on building's design.
- For the first time, District residents have a viable community-based public mental health system, with the DMH Community Services Agency at its core. The CSA and the other agencies certified by the Department to deliver Medicaid reimbursable services, now have 10,700 people enrolled.

- In fact, because we are overcoming the challenges of a dysfunctional information technology system, that 10,700 is a real number.
- People say there is no children's system of care. I acknowledge that is true, but, Chairperson Allen and members of the Council, let me reaffirm that I have no greater commitment than to create a system to help our children reach their full potential.
- Since November 2002, we kept 125 children from being sent to out-of-state residential treatment facilities because we are creating more local resources and making better use of those that already existed.
- Unlike any other District government agency, we are conducting labor contract negotiations ourselves and have completed seven of the eight contracts.
- Finally, just as we were gaining momentum for establishing the new mental health system, we had to divert our attention to providing care and comfort for all residents who were stunned by the series of emergencies that started with the terrorist attacks of September 11, 2001 and continue through today with the war in Iraq.
- This past weekend, we conducted a standing room only training conference for mental and medical health care providers who are being called upon to help residents handle their distress.
- I am very proud to be a mental health professional right here and right now. We all acknowledge that the District of Columbia is very likely to be targeted by terrorists, and my colleagues and I are here to help manage the stress, the anxiety and the fear living with that knowledge can cause.
- Yes, there are many challenges ahead, and I'm sure there are more lessons to be learned; but let me assure you, the DMH team

is fully prepared to meet those challenges and grow wiser with each new lesson.

FY 2003 INITIATIVES

DMH is:

- DMH is developing a new system of care for children and youth with the support of two multi-million dollar, multi-year grants. The first grant, D.C. CINGS (Children Inspired Now Gain Strength, pronounced “sings”), is an \$8,000,000, six-year grant from the U.S. Department of Health and Human Services, Center for Mental Health Services. Alternative Pathways, the second grant, is funded in its first year for \$2,000,000 from the Juvenile Justice Advisory Group. Together, these programs represent a major step by the city’s mental health system to address the diverse and comprehensive needs of children and their families.
- Implementing its school-based services in the transformation schools this fiscal year.
- On target for Medicaid and Medicare revenue collection.
- Developing a plan to address co-occurring disorders and services.
- Implementing the Court-ordered Plan.
- Awaiting response to the first administrative cost claim submitted to the Medical Assistance Administration for the overhead costs of the Medicaid Rehabilitation Option.
- Fully responsible for the Medicaid certification function for residential centers for children and youth, free-standing mental health centers and day treatment programs. This previously had been the responsibility of the Department of Health, Medical Assistance Administration. The DMH Office of Accountability now is solely responsible for processing applications from District and out-of-state providers to determine whether they meet federal and

District standards for federal financial participation in the Medicaid program.

- Exercising the authority to determine whether community-based housing, also known as supported independent living residences, that is supported by the Department, other than licensed community residential facilities, meet minimum health and safety standards. The Department developed these standards in response to recommendations issued by the District of Columbia Auditor to address deficiencies and lack of oversight in these residences. The Office of Accountability is developing the implementation plan to ensure compliance with these standards.
- Developing the first supported employment program. DMH was awarded a three-year grant from the Johnson & Johnson Foundation for \$320,000 to develop three Supported Employment Demonstration Projects to replicate evidence-based supported employment.
- Other initiatives for FY 2003 are mentioned elsewhere in this testimony.

FY 2004 BUDGET REQUEST

- The Mayor has proposed an operating budget for the Department of Mental Health of \$218,228,701. This consists of a Local budget allocation of \$152,162,000, which is a net increase of \$20,938,000 from the FY 2003 approved budget.
- The Local budget consists of \$82,434,965 for personal service and \$69,726,999 for nonpersonal services. There are 1,266 FTEs funded by Local sources.
- The proposed federal budget consists of \$9,059,000, which represents funds from federal beneficiaries, Medicare and federal grants and has decreased by \$58,041,000. There are 50 FTEs funded by the Federal Beneficiaries fund, which represents no change from FY 2003.

- The proposed Intra-District budget is \$56,948,000, which includes Medicaid revenue of \$53,155,000 and other intra-District funds of \$3,783,000 represents an increase of \$56,948,000 from the FY 2003 approved budget.
- The private budget consists of \$60,000 and represents a decrease of \$19,269,000 from FY 03. This decrease is related to the OBP reclassification of revenues into other funding categories.
- The FY2003 budget includes one-time funds for both Medicaid and Medicare. These funds emanate from settlements of previous year's cost reports. It is necessary to use these funds to plug a gap in FY2002. This gap came about because the full extent of the revenue collections problems within the Department were not known at the time the FY03 budget was developed.
- These problems, while largely rectified going forward, including inflated revenue estimates that came as a result of early counting of eligible hospital days for Medicare reimbursement at a higher level than allowable, no allowances made for bad debt and projections for services no longer reimbursable by Medicaid.

CAPITAL BUDGET

- The Department of Mental Health is on target in implementing the spending plan of its Capital Budget.
- To date we have completed the design concept for the new hospital building and are presently awaiting approval of our zoning so that we may begin construction.
- We have completed the consolidation of St. Elizabeths Hospital operations on the West Campus, which has allowed us the ability to provide better office environments for our staff, and reduce our utilities and personal services costs.
- We have opened and are using our new Howard Road facility for the DMH Community Services Agency's children and youth programs and their administrative offices.

- As you are aware, many of our buildings are very old and fragile. The North Center serves 2,000 consumers and houses 91 employees in 83,900 square feet. The infrastructure and utility systems are badly deteriorated and require immediate replacement. Failure to renovate will eventually lead to closing the building due to life safety issues, the inability to provide the necessary and adequate environment of care for consumers, and the eventual shutdown of elevators, which will provide no means of accommodating non-ambulatory consumers, staff and visitors. If the building is not renovated, maintenance and capital project costs will escalate at a rate of at least 5 percent per year.
- The Community Services Agency is held to the same Mental Health Rehabilitation Services standards as all other providers to comply with requirement 3410.28 (a-I). “Each MHRS provider’s service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group counseling sessions in consumer interview rooms.” “All areas of the MHRS provider’s service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.”
- Also, the CT (continuing treatment) buildings on the East Campus of St. Elizabeths need to be renovated as they are part of the plan for the new hospital and will provide additional beds, if needed. Since their renovation does not require zoning, we can begin to renovate with this funding to ensure their readiness before any patients or staff move to the new hospital building.
- We are also required to provide housing for consumers. We have developed housing this fiscal year and have leveraged our funds to achieve additional housing.
- We urge approval of our capital request of \$5.5 million for FY 2004, which is critical to the safety and health of consumers as they work toward recovery from mental illness.

IMPROVING FINANCIAL CONTROLS

- Overall, the Department implemented a number of internal cost controls to aggressively manage spending in FY 2002, which will have an impact on both the FY 2003 and FY 2004 budgets. The move of operations from the West Campus to the East Campus of St. Elizabeths Hospital produced a reduction in fixed costs per client from \$1,275 in FY02 to \$858 in FY03, with a projection of \$819 for FY04.
- In addition, the Department conducted administrative reviews of our fleet management, resulting in a reduction of the Department's fleet by 37 vehicles for an annual savings of \$145,523 in lease and maintenance costs. We have implemented controls on cellular phone usage as illustrated in the chart below, thus reducing our cost from a high in April 2002 of \$31,418 to \$15,975 in January 2003.
- Finally, we looked at our costs of duplication as illustrated below and we were able to consolidate contracts and purchase up-to-date digital networked copiers with fax printing and scanning capability. We were able to reduce costs per copier to \$146 per copier over our FY02 cost for an annual saving of more than \$14,000.
- At the beginning of FY 2003, DMH contributed \$10,150,000 to help reduce the District's budget gap caused by plummeting revenues. That reduction is carried over to our FY 2004 base budget request of \$218,228,701 million.
- In FY2001 the Transitional Receiver had a nonpersonal services and contract services budget of \$27,134,280. In FY 2002 we reduced this to \$12,863,319. In FY 2003 we reduced this again to \$12,754,805.
- This fiscal year we have successfully completed contracts with seven of our eight unions and stayed within our budget. The nurses union contract has not yet been completed, but we anticipate completing this contract within this fiscal year. If ratified, these contracts, it is projected, will have an impact of approximately \$2.4 million in FY 2003 and \$4.8 million in FY

2004.

- The continuous reduction in the use of personal services and goods and services contracts will help enable DMH to meet this commitment to labor.

MEDICAID

- As you are aware, the Department uses Medicaid as a major funding source for community-based services and seeks to maximize Medicaid reimbursement at the service and administrative levels.
- DMH administers, through an agreement with the Medical Assistance Administration (MAA), portions of the state Medicaid program that pertain to mental health.
- Most consumers of DMH services are Medicaid recipients. The Department reports that approximately 69 percent of those on the rolls of the DMH are Medicaid eligible. In FY 2004, DMH projects Medicaid reimbursement of approximately \$53,155,038 for mental health services to be provided to eligible District residents.
- The projected Medicaid revenue of \$53,155,038 represents a decrease of \$10,000,000 from FY 2003. FY 2003 Medicaid revenue will include one-time revenue collected from previous years' cost report settlements.
- The Medicaid fund represents the following categories: inpatient psychiatric services, disproportionate share hospital payment (DSH), administrative services, Medicaid Rehabilitation Option (MRO), and outpatient services.
- Medicaid revenues fund both personal and nonpersonal services for the Mental Health Authority, St. Elizabeths Hospital, and the Community Services Agency. The FY 2004 budget included Medicaid-funded expenditures and their related Local funds match. There are 590 FTEs funded via these revenues.

FY 2004 GOALS

DMH will:

- Increase the penetration rate of mental health services rendered to children, youth and adults living in the District of Columbia.
- Recoup reimbursable revenue for eligible services for eligible consumers.
- Develop and implement a consumer-driven and recovery-focused system of care that meets the needs of consumers and their families and the exit criteria of the Dixon order in to end the Court Monitoring phase of the Department of Mental Health by FY 2006.
- Reduce the out- of-District placements for children placed by the Department by replacing these services with more appropriate, cost-effective services.
- Forge strong partnerships with other agencies, providers and community groups to provide effective mental health services.
- Create the necessary infrastructure of technology, communications tools and staff development to support the strategic direction of this Department.
- Meet District-wide standards for customer service.
- Open a new building for St. Elizabeths Hospital by 2005 to provide a recovery-based environment for consumers.
- Expand housing options for DMH consumers.
- Comply with the Health Insurance Portability and Accountability Act (HIPAA).
- Expand children's service initiatives, including school-based services.

"RECOVERY" AS THE OVERALL CONTEXT FOR SERVICE DELIVERY

- Adopting the recovery model was the first step we took to transform the public mental health system. We use the term "recovery" to describe our philosophy of care of restoring relationships, dignity, and self-respect lost to mental illness.
- Within the recovery model, we use a team approach. The consumer, the consumer's family or significant others, and service providers together identify the consumer's needs and work towards the consumer's choice of long- and short-term goals.
- Treatment is individually based. The recovery model:
 - Focuses on abilities, interests, and skills.
 - Focuses on the person within their community.
 - Focuses on action.
- In the past, there was only the medical model for mental health treatment. The consumer was treated by medical clinicians within medical settings, and the outcome was focused on reducing symptoms. The recovery model, however, focuses on regaining function and recovering abilities. At DMH, we are using the two models in our work.
- When we integrate the recovery model with the Mental Health Rehabilitation Services system, the result is the means for consumers to improve their ability to function in society as productive adults or children.
- The domains of life – jobs, family, education, health, religion and social interaction – are just as important to people with mental illness as they are to people who are not mentally ill. They define us, they give us comfort and strength, they motivate us.
- For a people with mental illness, often what is absent from their lives is the ability to dream, to aspire to a better life. Within the recovery model, through the treatment planning process, we help

consumers define their aspirations. For those who have lost their ability to dream, we help them to acquire aspirations. The starting point is when the consumer says, “I want to do . . .”

- By refocusing our outcome from managing or controlling symptoms to achieving independence, for instance, we are able to introduce different disciplines beyond those of mental health professions. Now we look at outcomes as being infinite.
- We continue to use psychotherapy within the Mental Health Rehabilitation Services system adopted in 2001 and followed by all providers certified by the Department to deliver Medicaid-reimbursable services.
- As with all services to be provided an individual consumer, the diagnosis is the determining factor, whether the person has severe and persistent mental illness or other less severe mental illness. We now have a wider range of psychotherapeutic interventions that can be used to the consumer's benefit, again, based on diagnosis.
- There are multiple psychotherapies. Today, we can take advantage of the short-term, focused, outcome-oriented psychotherapies, which are effective for specific kinds of problems, and can be applied by highly trained and licensed social workers and other clinicians, as well as psychologists.
- These psychotherapies are targeted on treating a set of symptoms. The psychotherapist and consumer develop a treatment plan that includes how long it will take, what's going to take place in each session and what will be the outcome.
- The consumer is taught to recognize symptoms, ways of thinking and acting to control the symptoms; and the consumer is given homework. Consumer and clinician talk about the homework, and they practice the techniques.
- Courses are taught in these short-term, focused psychotherapies. Manuals provide the sequence as well as what complications the

therapist should expect at each stage. The psychotherapies are tied to specific outcomes. It's very structured, symptom-focused and akin to the medical model.

- We also retain use of the more commonly-known psychotherapeutic intervention that is open-ended, features long-term goals and is guided by the analyst.
- The key point is that the diagnosis determines the best type of intervention to be provided within the spectrum between counseling and psychotherapy.
- Psychologists have a unique role in this new service delivery structure because of their specialized training and expertise in psychological testing and evaluation. In fact, a significant aspect of training at the Ph.D. level is in assessment and the use of assessment instruments. Psychologists are the only clinicians credentialed to use them. Psychiatrists cannot do this testing.
- Psychologists will serve as resources for each of our more than 30 treatment teams.
- In establishing the Mental Health Rehabilitation Services, DMH closely followed the standards set forth by the Agency for Health Policy and Research and the National Institute of Mental Health for treatment of persons with schizophrenia, major depressive disorders and less severe depression.
- These findings have been translated into consensus guidelines and algorithms for treatment. The strongest consensus and supportable findings are for six interventions in illness management, including self-management; case management, based on principles of assertive community treatment; family; psychoeducation; supported employment; and integrated substance abuse treatment.
- These standards require that each consumer have a clinical manager. Clinical managers and other qualified practitioners include licensed and properly credentialed mental health professionals in

social work, nursing, psychiatry, professional counseling and psychology.

- MHRS consists of a range of services that evidenced-based practices indicate best aid people in the recovery process.

PERFORMANCE-BASED BUDGETING

- Our FY 2004 budget is our first venture into performance-based budgeting. My staff and I are fully committed to linking performance to budget to achieve the obvious benefits of program effectiveness and fiscal control.

Strategic Management Services

- The purpose of the Strategic Management Program is to provide planning, policy development and mental health system design for the District of Columbia to create a comprehensive and responsible system of mental health care.
- These functions are carried out by the Mental Health Authority and are largely based upon the director's performance contract, the Dixon court order and the exit criteria. This function comprises part of the 15% of DMH's budget for administration cost.

Service Delivery System

- The purpose of the Service Delivery System Program is to provide the design, development and communication of mental health services to enable access to services that support recovery and resilience.
- These functions are administered by the Mental Health Authority and are largely supported by federal grant money, particularly in the area of the development of a system of care for children and our diversion program.

- We are leveraging our capital funds for housing programs for consumers and are able to create many housing opportunities by wisely using our funding.
- The Access HelpLine has improved services for our consumers and has created capacity to serve consumers 24 hours a day, seven days a week.
- This program also is part of the 15% of the budget that is used for Administration.

Administration (Administration And Central Services Support)

- The purpose of the Administration and Central Support Program is to provide accountability and compliance by private providers, as well as, oversight of the newly-developed mental health care system, which includes St. Elizabeths Hospital and the DMH Community Services Agency (public Core Service Agency).
- This program is a part of the 15% of the budget for administration.

Facilities and Support Management

- The purpose of the Facilities and Support Management Program is to provide housekeeping, building maintenance and nutritional services in a clean, safe and healthy hospital environment for patients, families and employees so they can receive quality care.
- This program is St. Elizabeths Hospital and it comprises part of the 85% of the budget for services.

Direct Community Care for Children, Youth, Families and Adults

- The purpose of Direct Community Care for Children, Youth, Families and Adults is to provide prevention, comprehensive assessments, linkage, treatment and emergency services to promote resilience and recovery for children, youth, families and adults.

- The DMH Community Services Agency is part of the 85% of the budget for services.

Program and Clinical Services

- The purpose of Program and Clinical Services is to ensure staff credentialing, licensing, privileging and provision of medication and medical support services to eligible consumers in order to effectively treat mental illness and enhance their recovery.
- This program is housed in the DMH Community Services Agency and is a part of 85% of the budget, which covers services. It is important to note that out-patient pharmacy and medical services have been analyzed for two purposes: 1. To determine how to operate the out-patient pharmacy within the purview of the law, and; 2. How to best serve consumers with respect to medical services, which are not a part of the mission the Department of Mental Health.
- Additionally, these two areas have been very costly in the past and we are getting better control of both to best determine how to control costs and render quality services.

Direct Patient Care

- The purpose of the Direct Patient Care Program is to provide medical, psychiatric and psycho-social rehabilitation services for the patients of St. Elizabeths Hospital so they can receive prescribed care and recover.
- This program is housed at St. Elizabeths Hospital and is a part of the 85% of the budget that covers services.

Legally Mandated

- The purpose of the Legally Mandated Program is to provide whatever services are necessary to remain in full compliance with all requirements.

- This program is a reporting function to maintain compliance with all laws and court orders.
- This program is housed within the hospital and the Mental Health Authority. Additionally, the Office of the Corporation Counsel plays a large role in this area.

Agency Management

- The purpose of this program is to provide high performance, quality services, and cost efficiencies within DMH. This program is housed within the Mental Health Authority and comprises part of the 15% of the budget for administration.

CONCLUSION

- Thank you for hearing my testimony. Mayor Williams' demonstrated support for our implementation of the Court-ordered Plan and the work we are doing to satisfy the final vestiges of receivership, the exit criteria. The new mental health system truly is a work in progress. We ask that you support the Mayor's budget request for us to continue our work.
- My staff and I are available to answer your questions. Thank you.